INSTRUCTIONS FOR THE COMPLETION OF THE HEARING AID REQUEST FORM (PA/ARF1)

ELEMENT 1 - PROCESS TYPE
Enter process type 123 when requesting service.

ELEMENT 2 - AUDIOLOGICAL CENTER NAME
Enter the name of the audiological center.

ELEMENT 3 - PROVIDER NUMBER
Enter the eight digit provider number of the audiological center.

ELEMENT 4 - REQUESTING AUDIOLOGIST'S NAME/NUMBER
Enter the requesting audiologist's name and eight digit provider number in this element.

ELEMENT 5 - AUDIOLOGICAL CENTER ADDRESS
Enter the address, including zip code, of the audiological center.

ELEMENT 6 - AUDIOLOGICAL CENTER TELEPHONE NUMBER
Enter the telephone number, including area code, of the audiological center.

ELEMENT 7 - REFERRING PHYSICIAN'S NAME/NUMBER
Enter the name and provider number of the referring physician indicated on the PA/OF form.

ELEMENT 8 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER
Enter the recipient's complete ten digit medical assistance number as it appears on his/her medical assistance identification card.

ELEMENT 9 - RECIPIENT'S NAME
Enter the recipient's last name, first name and middle initial as they appear on his/her medical assistance identification card.

ELEMENT 10 - RECIPIENT'S ADDRESS
Enter the complete address of the recipient's place of residence. If the recipient is a nursing home resident, indicate the name of the nursing home.

ELEMENT 11 - DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (i.e., January 2, 1932 would be 01/02/32).

ELEMENT 12 - RECIPIENT'S SEX
Enter an 'X' in the appropriate box relating to the sex of the recipient.

ELEMENT 13 - DIAGNOSIS
Enter an ICD-9-CM (International Classification of Disease, 9th Revision, Clinical Modification) diagnosis code and written narrative description of the recipient's diagnoses.

ELEMENT 14 - PLACE OF SERVICE
Enter the appropriate place of service as listed on the table below:

Inpatient Hospital	1
Outpatient Hospital	2
Office	3
Home	4
Nursing Home	7
Skilled Nursing Facility	8
Independent Lab	A

ELEMENT 15 - TYPE OF SERVICE
Enter type of service 'P' for purchase of hearing aid and 'R' for rental of hearing aid.

ELEMENT 16 - PROCEDURE CODE
Enter the appropriate procedure code of the hearing aid requested.

ELEMENT 17 - TYPE OR LIKE MODEL
Enter a narrative description of the type or like model of hearing aid requested.

ELEMENT 18 - QUANTITY
Enter the quantity to be dispensed.

ELEMENT 19 - CHARGES
Enter your usual and customary charge for each item requested. NOTE: Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and policy.

ELEMENT 20 - DATE
The date the requesting audiologist signed the request must be entered in this element.

ELEMENT 21 - SIGNATURE
The signature of the requesting audiologist is required in this element.